Department of HUMAN SERVICES

Integrated Health Home Workgroup Meeting March 30, 2022

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Role Call

Format of Workgroup

- Discuss prior meeting (high level)
- Topic for the meeting
- Plan and expectations for next meeting

It is ok to ask questions during the meeting and between meetings. These questions and answers will be shared at the beginning of each meeting.

What is Our Why? What Do We Want to Accomplish?

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Ground Rules

- You can respect another person’s point of view without agreeing with them.
- Respectfully challenge the idea, not the person and bring potential solutions.
- Blame or judgment will get you further from a solution, not closer.
- Honest and constructive discussions are necessary to get the best results.
- Listen respectfully, without interrupting.
- Listen actively and with an ear to understanding others' views. (Don’t just think about what you are going to say while someone else is talking.)
- Commit to learning, not debating. Comment in order to share information, not to persuade.
- Avoid blame, speculation, and inflammatory language.
- Allow everyone the chance to speak.

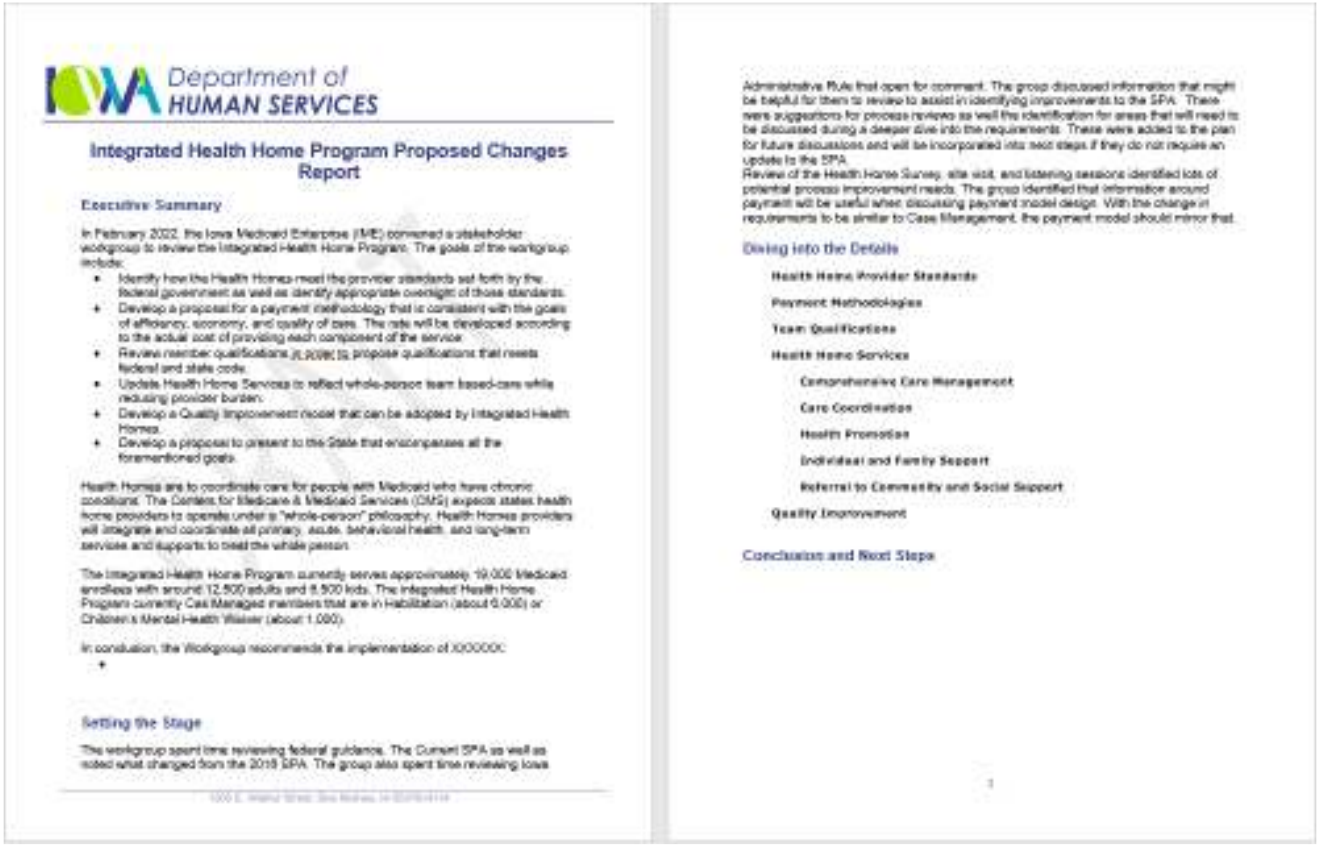
Objectives

- Review of Last Meeting
- Workgroup Report
- Provider Standards Deep Dive
  - How does the Health Home Meet?
  - Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available.
  - Managing Habilitation and CMHW
  - How does the MCO/Iowa Medicaid support and oversee?
  - Address feedback of MCO/IME Administrative Oversight Burden
  - Using the larger organization to support the work

Last Meeting

- Reviewed the timeline and plan for the next few months
- Met with Karen Hyatt from DHS and Kellie McCrory University of Iowa to discuss Peer/Family Peer.
- Discussed brainstorming activity to assist in creating robust discussions.
- Questions/Answers

Workgroup Report



Department of HUMAN SERVICES

Integrated Health Home Program Proposed Changes Report

Executive Summary

In February 2022, the Iowa Medicaid Enterprise (IME) convened a stakeholder workgroup to review the Integrated Health Home Program. The goals of the workgroup include:

- Identify how the Health Homes meet the provider standards set forth by the federal government as well as identify appropriate oversight of those standards.
- Develop a proposal for a payment methodology that is consistent with the goals of efficiency, economy, and quality of care. The rate will be developed according to the actual cost of providing each component of the service.
- Review member qualifications in order to propose qualifications that meets federal and state code.
- Update Health Home Services to reflect whole-person team based-care while reducing provider burden.
- Develop a Quality Improvement model that can be adopted by Integrated Health Homes.
- Develop a proposal to present to the State that encompasses all the forementioned goals.

Health Homes are to coordinate care for people with Medicaid who have chronic conditions. The Centers for Medicare & Medicaid Services (CMS) expects states health home providers to operate under a "whole-person" philosophy. Health Homes providers will integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

The Integrated Health Home Program currently serves approximately 19,000 Medicaid enrollees with around 12,500 adults and 6,500 kids. The Integrated Health Home Program currently Case Managed members that are in Habilitation (about 6,000) or Children's Mental Health Waiver (about 1,000).

In conclusion, the Workgroup recommends the implementation of XXXXXX:

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Setting the Stage

The workgroup spent time reviewing federal guidance, The Current SPA as well as noted what changed from the 2018 SPA. The group also spent time reviewing Iowa

Administrative Rule that open for comment. The group discussed information that might be helpful for them to review to assist in identifying improvements to the SPA. There were suggestions for process reviews as well the identification for areas that will need to be discussed during a deeper dive into the requirements. These were added to the plan for future discussions and will be incorporated into next steps if they do not require an update to the SPA.

Review of the Health Home Survey, site visit, and listening sessions identified lots of potential process improvement needs. The group identified that information around payment will be useful when discussing payment model design. With the change in requirements to be similar to Case Management, the payment model should mirror that.

Diving into the Details

Health Home Provider Standards

Payment Methodologies

Team Qualifications

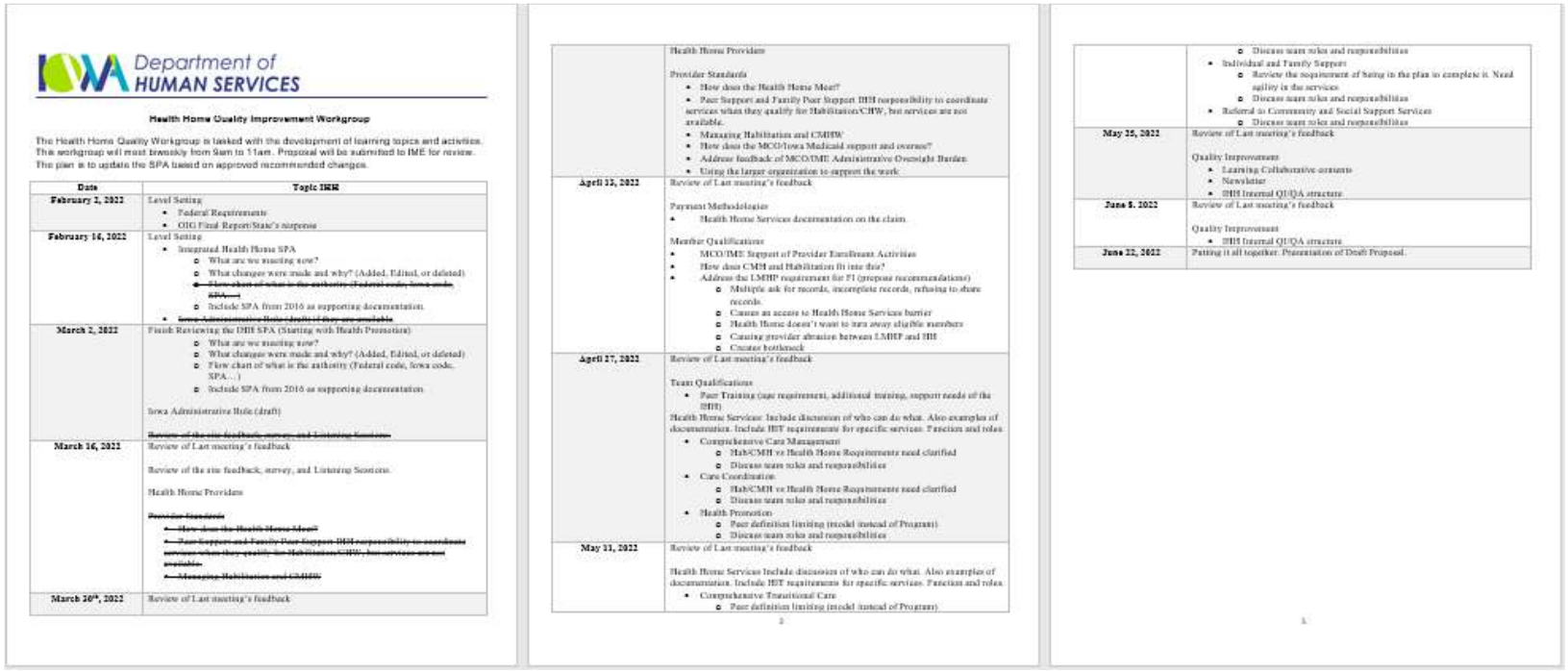
Health Home Services

- **Comprehensive Care Management**
- **Care Coordination**
- **Health Promotion**
- **Individual and Family Support**
- **Referral to Community and Social Support**

Quality Improvement

Conclusion and Next Steps

Overview of the Timeline



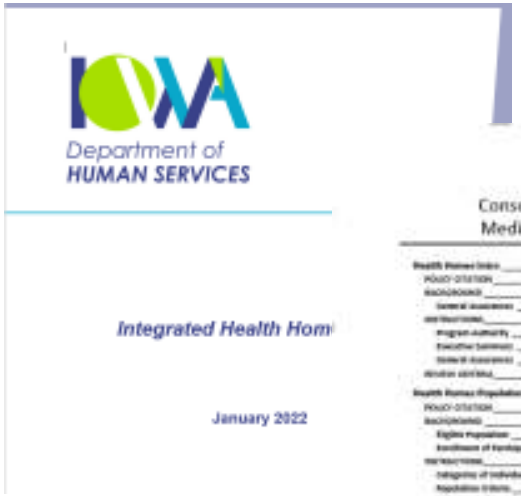
Department of HUMAN SERVICES

Health Home Quality Improvement Workgroup

The Health Home Quality Workgroup is tasked with the development of learning topics and activities. This workgroup will meet biweekly from 9am to 11am. Proposal will be submitted to IME for review. The plan is to update the SPA based on approved recommended changes.

Date	Topic IHH
February 2, 2022	Level Setting • Federal Requirements • OIG Final Report/State's response
February 16, 2022	Level Setting • Integrated Health Home SPA o What are we meeting now? o What changes were made and why? (Added, Edited, or deleted) ~~• Flow chart of what is the authority (Federal code, Iowa code, SPA…)~~ o Include SPA from 2016 as supporting documentation. ~~• Iowa Administrative Rule (draft) (for your review)~~
March 2, 2022	Finish Reviewing the IHH SPA (Starting with Health Promotion) o What are we meeting now? o What changes were made and why? (Added, Edited, or deleted) o Flow chart of what is the authority (Federal code, Iowa code, SPA…) o Include SPA from 2016 as supporting documentation. Iowa Administrative Rule (draft) ~~Review of the site feedback, survey, and Listening Sessions~~
March 16, 2022	Review of Last meeting's feedback Review of the site feedback, survey, and Listening Sessions. Health Home Providers ~~Provider Standards~~ ~~• How does the Health Home Meet?~~ ~~• Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available.~~ ~~• Managing Habilitation and CMHW~~
March 30th, 2022	Review of Last meeting's feedback
	Health Home Providers Provider Standards • How does the Health Home Meet? • Peer Support and Family Peer Support IHH responsibility to coordinate services when they qualify for Habilitation/CHW, but services are not available. • Managing Habilitation and CMHW • How does the MCO/Iowa Medicaid support and oversee? • Address feedback of MCO/IME Administrative Oversight Burden • Using the larger organization to support the work
April 13, 2022	Review of Last meeting's feedback Payment Methodologies • Health Home Services documentation on the claim. Member Qualifications • MCO/IME Support of Provider Enrollment Activities • How does CMH and Habilitation fit into this? • Address the LMHP requirement for FI (propose recommendations) o Multiple ask for records, incomplete records, refusing to share records o Causes an access to Health Home Services barrier o Health Home doesn't want to turn away eligible members o Causing provider abrasion between LMHP and IHH o Creates bottleneck
April 27, 2022	Review of Last meeting's feedback Team Qualifications • Peer Training (age requirement, additional training, support needs of the IHH) Health Home Services: Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles • Comprehensive Care Management o Hab/CMH vs Health Home Requirements need clarified o Discuss team roles and responsibilities • Care Coordination o Hab/CMH vs Health Home Requirements need clarified o Discuss team roles and responsibilities • Health Promotion o Peer definition limiting (model instead of Program) o Discuss team roles and responsibilities
May 11, 2022	Review of Last meeting's feedback Health Home Services Include discussion of who can do what. Also examples of documentation. Include HIT requirements for specific services. Function and roles • Comprehensive Transitional Care o Peer definition limiting (model instead of Program)
	o Discuss team roles and responsibilities • Individual and Family Support o Review the requirement of being in the plan to complete it. Need agility in the services o Discuss team roles and responsibilities • Referral to Community and Social Support Services o Discuss team roles and responsibilities
May 25, 2022	Review of Last meeting's feedback Quality Improvement • Learning Collaborative sessions • Newsletter • IHH Internal QUQA structure
June 8, 2022	Review of Last meeting's feedback Quality Improvement • IHH Internal QUQA structure
June 22, 2022	Putting it all together. Presentation of Draft Proposal.

Documents for Today



11 Health Home Core Functions

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered health home services.
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.
- Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.
- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
- Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Delivery System Principles

- Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols.
- Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.
- Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.
- Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.
- Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.
- Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.).
- Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings.
- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
- Use data for population health management, tracking tests, referrals and follow-up, and medication management.
- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.

Provider Standards

Principles

- A fundamental truth or proposition that serves as the foundation for a system of belief or behavior or for a chain of reasoning.
- Morally correct behavior and attitudes.

Function

Work or operate in a proper or particular way.

Considerations

- How does the Health Home meet provider standards
- How does Lead Entity oversee along with IME to ensure standards are met (Federal requirement) without being overly burdensome.

To support the key Health Home service delivery system principles, CMS recommends that Health Home providers use one of the following options:

- Meet state specific standards for a patient-centered medical home/Health Home which, at a minimum, encompass the health home delivery system requirements (listed below), or
- At state option, be accredited by a national accreditation organization that has standards equal to or more stringent than applicable state-specific standards.

States will need at a minimum, to include a designated provider or team of health care professionals that includes, employs, contracts with, or otherwise has access to interdisciplinary teams that consist of the following:

- Primary care physician/nurse practitioner
- Nurse
- Behavioral health care provider
- Social work professional
- Other providers appropriate for the condition of the enrollees

Degrees, certifications, and licensures, for Health Home Team

Describe the qualifications and standards that must be met in order for that kind of professional/provider to participate in the Health Homes program, including professional degrees, certifications and licenses to practice in the state and the capability to provide all six Health Homes services

Demonstrate clinical competency for serving the complex needs of health home enrollees using evidence-based protocols

Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines.

Demonstrate the ability for effectively coordinating the full range of medical, behavioral health, long-term services and supports, and social services for medically complex individuals with chronic conditions.

- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders.
- Coordinate and provide access to mental health and substance abuse services.
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families.
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services.
- Coordinate and provide access to long-term care supports and services.

Provide health home services that operate under a "whole-person" approach to care using a comprehensive needs assessment and an integrated person-centered care planning process to coordinate care.

Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services.

Conflict of Interest

Have conflict of interest safeguards in place to assure enrollee rights and protections are not violated, and that services are coordinated in accordance with enrollee needs expressed in the person-centered care plan, rather than based on financial interests or arrangements of the health home provider.

Timely Access

Provide access to timely health care 24 hours a day, 7 days a week to address any immediate care needs of their health home enrollees.

Protocols to Communicate with the Member's Providers.

Have in place operational protocol, as well as communication procedures to assure care coordination across all elements of the health care system (hospitals, specialty providers, social service providers, other community-based settings, etc.).

Have protocols for ensuring safe care transitions, including established agreements and relationships with hospitals and other community-based settings

Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.

Continuous Quality Improvement

- Establish a continuous quality improvement program that includes a process for collection and reporting of health home data for quality monitoring and program performance; permits evaluation of increased coordination and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.
  - Establish a continuous quality improvement program and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

Population Health

Use data for population health management, tracking tests, referrals and follow-up, and medication management.

Health Information Technology

- Use health information technology to link services and facilitate communication among interdisciplinary team members and other providers to coordinate care and improve service delivery across the care continuum.
  - Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate.

Next Steps

- Review of this meeting's feedback
- Review updated Workgroup Report
- Review follow-up from prior meeting